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Introduction

According to industry studies, an employer-sponsored health care plan has been the most highly desired benefit for employees for several years. The Health Care Commission and the Division of Personnel Services strive to provide its employee benefits membership with high quality, cost-effective choices in the Health Plan and associated benefit offerings such as KanElect and HealthQuest.

One of the fundamental goals of the state Health Plan is to help ensure that our members have access to the safest and highest quality health care and can make informed health care decisions. Participants are encouraged to carefully review their Health Plan options and take advantage of tools such as the benefit descriptions and Plan Comparison Chart in this booklet and the web site information and links on the Benefits web page: http://da.state.ks.us/ps/benefits.htm.

Plan Year 2003 Health Plan

The Dental and Prescription Drug plan providers are unchanged for Plan Year 2003, although there may be some changes in participating service providers. Members should check the directories (via web or toll free number) for information on providers.

The health plans will continue to offer for Plan Year 2003: three (3) types of Medical Plan Designs and seven (7) providers from which to choose:

Health Maintenance Organizations (HMO):

- Premier Blue
- Mid America Health
- Preferred Plus of Kansas
- Coventry Health Care

Preferred Provider Organizations (PPO):

- Preferred Health System Insurance Company (PHSIC)
- Kansas Prefer - using the Private HealthCare Systems (PHCS) network

Managed Indemnity Plan:

- Kansas Choice

There is a new vision service provider Supervision Vision Services for Plan Year 2003. The plan offers enhanced benefits, but a different provider network.

There are no major Health Plan or Flexible Spending Accounts (FSA) Plan design changes for 2003.

A new Health Risk Appraisal for employees is being implemented which is a proactive replacement for the active employees' non-tobacco users discount.

Following this section is a summary comparison chart, which highlights the benefits of the various medical plan designs along with the costs for certain services (expressed as deductibles, copays and coinsurance). Other sections of this booklet contain explanations of the various plans and the member premium amounts.

Membership education and awareness are critical components of the Health Plan. Members are encouraged to read this Open Enrollment Booklet to fully understand their range of benefit choices and to make wise consumer decisions. The Benefits Administration Section, service providers, agency Human Resources staff and the Division of Personnel Services web pages (and links) can also assist employees in the decision making process.

Open Enrollment Dates

Open Enrollment for health plans and Flexible Spending Accounts begins on Tuesday, October 1, 2002 and continues through Thursday, October 31, 2002. Open Enrollment elections will become effective on January 1, 2003 for health plans and Flexible Spending Accounts.

Open Enrollment using AKSESS

The primary way to enroll for Plan Year 2003 is through the Internet, using AKSESS.

- Health Plans: Employees must complete web enrollment for Plan Year 2003 if they change medical/dental plan, add, drop or change vision coverage or their own medical coverage, add or drop dependents from medical, dental or vision coverage.

- Web enrollment is also required for members to register for Health Risk Appraisal participation, which replaces the non-tobacco user discount.

- Pretax Status and Flexible Spending Accounts (FSA): Web enrollment is also required to change pretax payment status. Employees electing to participate in either the Dependent Care or the Health Care FSA(s) through KanElect in Plan Year 2003 must complete a new election. **Participation will end on December 31, 2002 unless new enrollment is elected for Plan Year 2003.**

- Employees are encouraged to go to AKSESS to review current elections even if they do not wish to make any changes to coverage or pretax payment status, do not desire to take advantage of the Health Risk Appraisal Credit or do not wish to enroll in a Flexible Spending Account.

Another section of this booklet contains general instructions for Open Enrollment on the Internet.

Meetings

Open Enrollment meetings will be held at various locations throughout the State giving employees the opportunity to discuss benefit options. Selected meetings will be attended by insurance plan representatives, Health Benefits Administration staff, KanElect representatives, and representatives from other benefit plans. Employees are strongly encouraged to attend an Open Enrollment meeting.

Employer Contribution for Cost of Coverage and Rate Charts

For full-time employees, the State of Kansas makes an employer contribution towards the total cost of coverage. In general, the State contributes approximately 95% toward the cost of the "employee" coverage and about 35% towards the cost for dependents. Employees pay the balance of the premium depending on salary range, coverage range and specific plan. Salary ranges for Plan Year 2003 are unchanged:

- Employees earning less than $25,000 annually (range 1)
- Employees earning at least $25,000 but less than $44,500 annually (range 2)
- Employees earning $44,500 or more annually (range 3)

For part-time employees, the State of Kansas generally contributes 75% of the amounts contributed for full-time employees.

Rate charts are located in the providers' sections of this booklet. The rates in each provider section include medical and prescription drug coverage only. Dental rates are listed separately in the Dental Section; vision rates are listed separately in the Vision Section.

Participants who agree to complete a Health Risk Appraisal receive a $5.00 credit per semi-monthly deduction period. The Health Risk Appraisal credit is applied to the dental rate calculations for administrative purposes only (displayed in the Dental Section of this booklet).

Effective Dates, Coverage Periods and Deductions

Effective Dates – Open Enrollment coverage elections for both the Health Plan and KanElect Flexible Spending Accounts (FSA) for Plan Year 2003 become effective on January 1, 2003. Medical and dental appointments for January 1st and later should be made with the understanding that Plan Year 2003 coverage will be in effect at that time.

Monthly Coverage—Coverage periods are monthly for the Health Plan and KanElect FSA. This means that new enrollments or changes in enrollment and/or coverages will generally begin on the first day of the month. Terminations of coverage or ineligibility for coverage will be effective on the last day of the month.

Semi-Monthly Deductions—Employee contributions for Health Plan and KanElect FSA are deducted on a semi-monthly basis, or 24 (16 for certain Regents employees) times per year. The first paycheck in January 2003 will pay for the first half of January's coverage; the second paycheck in January 2003 will pay for the second half of January's coverage. For those months during plan year 2003 which have three paychecks (January and August), there will not be a deduction for health plans or KanElect FSA on the third paycheck of those months.

Identification Cards

New identification cards will be mailed as follows to the employee's home address starting in mid-December, 2002.

- Medical—new ID cards will be sent to those employees who are either changing medical plans or changing coverage level with their current medical plan.
- Prescription Drug—new ID cards will be sent only to those employees who are adding new coverage and/or adding new dependents.
- Dental—new ID cards will be sent only to those employees who are adding new coverage. New certificates of coverage will be sent to all participants.
- Vision—Employees who enroll in the vision program will be mailed ID cards and will receive a certificate of coverage.

Starting in January, if an employee has not received a new ID card or benefit summary as listed above, the employee should contact the health plan at the telephone number listed in the front of this booklet and request that ID cards or benefits summaries be resent.

Pre-Existing Conditions

The State of Kansas does not apply a waiting period for pre-existing conditions for newly enrolled employees and their dependents who enroll in health coverage at Open Enrollment. Therefore, employees who may have certificates of creditable coverage from other health plans are not required to use them if they elect coverage at Open Enrollment.

Benefits Guidebook

Employees should refer to the current Employee Benefits Guide at the State of Kansas website: http://da.state.ks.us/ps/benefits.htm for additional information and a listing of the rules regarding benefits coverages.

Health Plan Changes for Plan Year 2003

Premium Rate Increases – Members pay a percentage of the cost of health plan coverage based on the rate for each plan and on the employee's salary range. For Plan Year 2003, the employee portion of the semi-monthly premium will increase depending on the employee's salary range, coverage tier and the medical plan selected. There were no premium increases for plan year 2002. Since the state picked up those additional premium costs the plan's financial reserves were reduced to the minimum required amount required by statute to have an actuarially sound plan. The increases for 2003 represent the actual cost increases from 2001 and 2002.

Medical Plans:

Kansas Choice

Preferred Health System Insurance Company (PHSIC) (PPO)

Kansas Prefer using the PHCS network (PPO)

Coventry Health Care (HMO)

New Counties added: Riley and Brown County, KS

Mid America Health (HMO)

New County added: Johnson County, MO

Preferred Plus of Kansas (HMO)

New Counties added or removed: none

Premier Blue (HMO)

New Counties added or removed: none

Delta Dental Plan of Kansas

Coverage provided for oral examinations twice per plan year regardless of time interval between the two covered examinations.

Orthodontic treatment is covered up to $1,000 per lifetime when provided by any Delta Dental contracting provider. There is no longer a DPO requirement.

Benefits paid for treatment of an accidental injury will not apply to the annual maximum of $1,500 for other covered services. Claims for treatment of an accident, which injures the jaw or teeth, must first be reviewed by the dental plan before forwarding to the medical plan.

Prescription Drug Plan (AdvancePCS)

Copayments:

- Special case medications indexed from $60 to $70

Out of Pocket Copay Maximums (annual):

- Indexed from $2100 to $2400

Specialty Rx Program for certain high cost prescriptions will be available for members who choose to utilize the service.

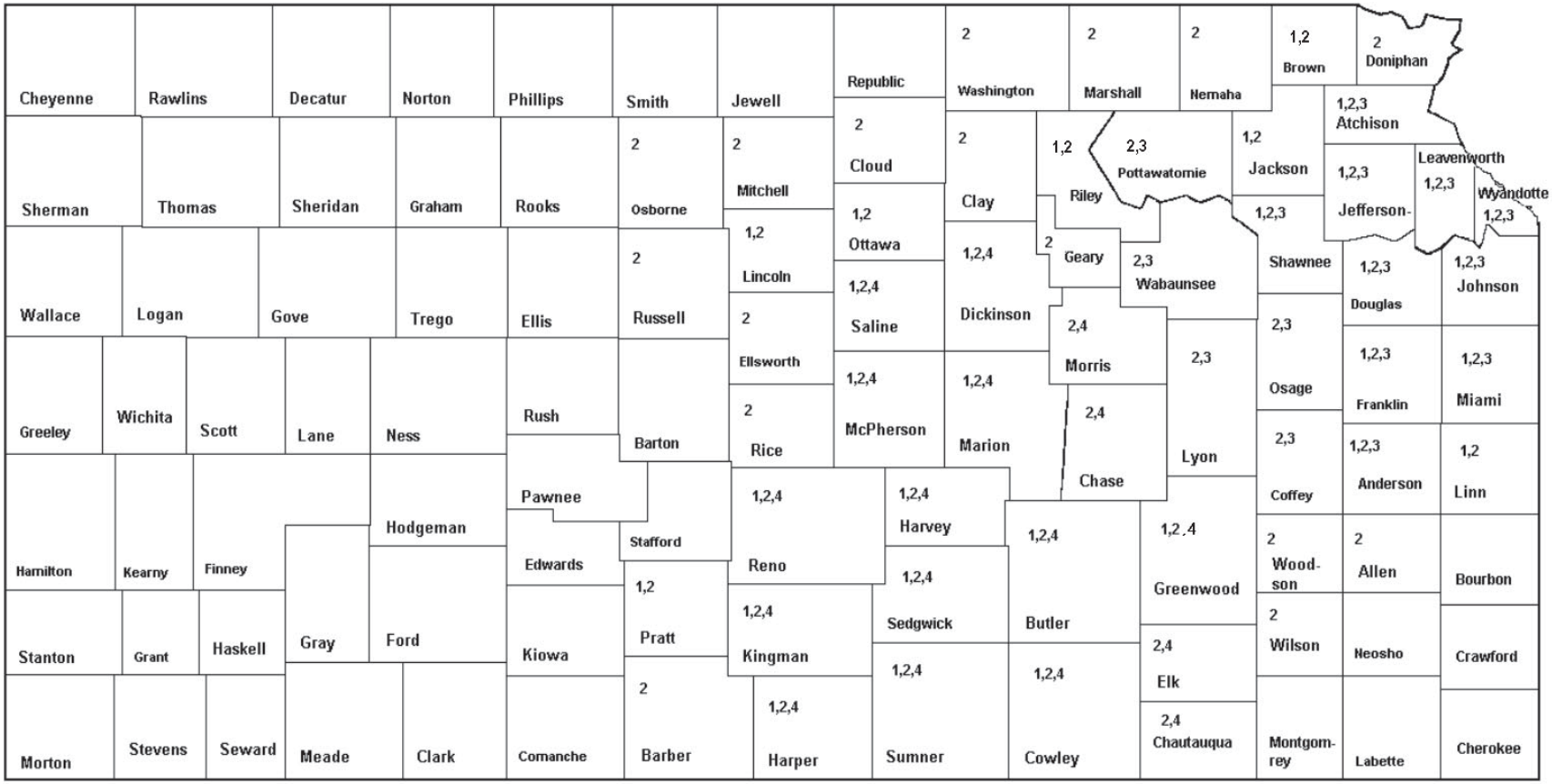
Health Risk Appraisal

- A Health Risk Appraisal credit is being implemented to replace the non-tobacco user discount. Additional information about this new opportunity is contained in the HealthQuest section.

Vision Plan

- Superior Vision is the new provider.
- Two levels of coverage for employees to select (remains voluntary): Basic or Enhanced (see Superior Vision section for details)
- Different provider network
- Members enrolled in the Vision Service Plan (VSP) will be automatically transferred into the equivalent Superior Vision plan. If coverage is not desired, employee must make an election to waive coverage in AKSESS.

2003 Enrollment Eligibility Plan Options by County



Eligibility for enrollment in Kansas Choice, Kansas Prefer, and Preferred Health Systems is in all counties in Kansas and Missouri and in most other states. Check with each of these health plans for locations of contracting physician and provider networks.

Eligibility for HMO enrollment is listed on the Kansas map above and/or on the Missouri counties listed below.

Key
1 = Coventry Health Care
2 = Premier Blue
3 = Mid America Health
4 = Preferred Plus of Kansas

KC MO
Benton - 1
Buchanan - 1,2
Caldwell - 1
Cass - 1,3
Clay - 1,2,3
Clinton - 1,3
Daviess - 1

KC MO
DeKalb - 1
Henry - 1
Jackson - 1,2,3
Johnson - 1,3
Lafayette - 1,3
Platte - 1,2,3
Ray - 1,3

2003 Plan Year
Medical Plan Comparisons by Plan Type

Medical Plan Type	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)		Managed Indemnity	
Medical Plans (Carriers) Offered	Coventry HealthCare MidAmerica Health Preferred Plus of Kansas Premier Blue	Kansas Prefer - using the PHCS network Preferred Health Systems (PHSIC)		Kansas Choice – using the Blue Choice network	
Deductible	$200 single/$400 family Inpatient Hospital Services Only	$200 single/$400 family		Network $300 single/$600 family	Non-Network $600 single/$1200 family
Coinsurance	80%/20% Durable Medical Equipment Only (maximum $5,000 covered services)	Network 90%/10%	Non-Network 70%/30%	Network 80%/20%	Non-Network 70%/30%
Coinsurance maximum	not applicable	Network $1,000/$2,000	Non-Network $3,000/$6,000	Network $2,000/$4,000	Non-Network $4,000/$8,000
Copayments	$10 per office visit $100 per outpatient surgery $50 per Emergency Room Visit	$15 Office Visit (network only) $75 per Emergency Room Visit $25 Outpatient mental health (network only)		$75 per Emergency Room Visit $25 Outpatient mental health (network only)	
Lifetime Benefit Maximum	$2,000,000 per person	$2,000,000 per person		$2,000,000 per person	
Primary Care Physician (PCP)	PCP manages and/or directs all care	PCP not required		PCP not required	
Provider Choice	Local Network, Referrals required for care not by Primary Care Physician	Freedom to use provider of choice, benefits based on plan description, coverage level based on provider network status		Freedom to use provider of choice, benefits based on plan description, coverage level based on provider network status	
Out of Network Care	Covered only for initial treatment of medical emergency or if pre-approved by health plan	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Out of Area Care	Must be Referred by PCP and Pre-Approved by Health Plan	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Amounts Above Plan Allowance	Provider to Write Off	Network Provider to Writes Off	Non-Network Member Responsibility	Network Provider to Writes Off	Non-Network Member Responsibility
Inpatient Services	Covered - Subject to Inpatient Deductible	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Physician Hospital Visits	Covered in full	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Emergency/Urgent Care Facility	$50 Copayment (waived if admitted)	$75 Copayment (waived if admitted) then Subject to Deductible and Coinsurance		$75 Copayment (waived if admitted) then Subject to Deductible and Coinsurance	
Home Health Care	Services Must be Pre-Approved by Health Plan Covered in Full - 50-visit maximum	Services Must be Pre-Approved by Health Plan Limited to $5,000 per benefit period		Services Must be Pre-Approved by Health Plan 100% to maximum of $2,500/year	
		Network Covered in Full	Non-Network Subject to Ded. & Coins.		
Hospice	Services Must be Pre-Approved by Health Plan Covered in Full	Services Must be Pre-Approved by Health Plan Limited to $5,000/Lifetime		Services Must be Pre-Approved by Health Plan Limited to $5,000/Lifetime	
X-Ray and Laboratory	Covered in Full	Subject to Deductible and Coinsurance (PET Scans require Pre-Approval by Health Plan)		Subject to Deductible and Coinsurance	
Surgery/Anethesia/Asst. Surgeon	Covered - If Outpatient, Subject to Copayment	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Physical Rehabilitation Services	Limited to 180 days if improvement documented at 30-day intervals, subject to applicable copayments	Services must be Pre-Approved by Health Plan Limited to 180 days if improvement documented at 30-day intervals, Subject to Deductible and Coinsurance		Limited to 180 days if improvement documented at 30-day intervals, Subject to Deductible and Coinsurance	
Durable Medical Equipment	Services Must be Pre-Approved by Health Plan and Subject to 20% Coinsurance, limited to $5,000 per person per year of covered services	Subject to Deductible and Coinsurance, limited to $4,500 per person per year		Subject to Deductible and Coinsurance, limited to $2,500 per person per year	

Note: The information in this chart is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the Certificate of Coverage or the Benefit Description. An employee may review the Certificate of Coverage or Benefit Description on the web at http://da.state.ks.us/ps/subject/benlink.htm. Provider directories are also available on the web site.

While the Kansas State Employee Health Plan has standardized the core benefits of the HMOs and PPOs, some individual plan differences do exist. Where there are differences, this comparison chart is written in such a way that all plans meet or exceed the benefits shown. For example, some plans require prior authorization for a particular service and others do not—the prior authorization requirement is shown. The member should work with their physician and health plan to ensure that they understand the coverage that will be available for the services they desire.

2003 Plan Year
Medical Plan Comparisons by Plan Type

Medical Plan Type	Health Maintenance Organization (HMO)	Preferred Provider Organization (PPO)		Managed Indemnity	
Inpatient Nervous & Mental/Drug & Alcohol	Subject to Inpatient Deductible 60-day Limit	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
		Network 60-day Limit	Non-Network 30-day Limit	Network 60-day limit	Non-Network 30-day limit
Outpatient Nervous & Mental/Drug & Alcohol	First 3 visits @ 100%, next 22 visits - $25 copay; additional visits @ 50%	Network first 3 @ 100%, next 22 @ $25 copay, additional visits @ 50%	Non-Network first 3 @ 100%, next 22 @ 50%, 25 visit limit	Subject to Deductible and Coinsurance	
				Network first 3 @ 100%, next 22 @ $25 copay	Non-Network first 3 @ 100%, next 22 @ 50%
Mental Health Parity	Benefits same as medical conditions for certian specified mental health conditions	Benefits same as medical conditions for certain specified mental health conditions		Benefits same as medical conditions for certain specified mental health conditions	
Preventive Care Services	As approved by Primary Care Physician and Subject to Office Visit Copayment	Network Preventive Care Allowance = 1st $300/person covered in full then Ded. & Coins.	Non-Network Limited and Subject to Deductible & Coinsurance	Limited and Subject to Deductible & Coinsurance	
Childhood Immunizations to age 5	Covered in Full	Covered in Full		Covered in Full	
Well-Woman Care (office visit and PAP smear test)	Subject to Office Visit Copayment – no referral required – Must use Network Provider	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Subject to Ded. & Coins.	Subject to Deductible and Coinsurance	
Mammogram (recommended frequency age 35-49 = 1 baseline; age 40-49 = every 2 years; age 50+ = annually)	Covered in Full – no referral required – Must use Network Provider	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Subject to Ded. & Coins.	Subject to Deductible and Coinsurance	
Well-Man Care (office visit and PSA blood test)	As approved by Primary Care Physician and Subject to Office Visit Copayment	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Limited and Subject to Ded. & Coins.	Subject to Deductible and Coinsurance	
Periodic Adult Physical Exam	Provided by Primary Care Physician and Subject to Office Visit Copayment	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Subject to Ded. & Coins.	Subject to Deductible and Coinsurance	
Dietitian Consultation (for medical management of a documented disease)	As approved by Primary Care Physician and Subject to Office Visit Copayment	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Not Covered	Not Covered	
Routine Hearing Exam	As approved by Primary Care Physician and Subject to Office Visit Copayment	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Not Covered	Not Covered	
Routine Vision Exam (Refraction Exam for Glasses – Lenses and frames NOT covered)	Limited to one per year Subject to Office Visit Copayment – Must use Network Provider	Network Preventive Care Allowance, then Ded. & Coins.	Non-Network Subject to Ded. & Coins.	Limited to one per year Subject to Deductible and Coinsurance	
Age Appropriate Bone Density Screening	As approved by Primary Care Physician and Precertified by Health Plan, Subject to Office Visit Copayment	Must be Pre-Approved by Health Plan		Must be Pre-Approved by Health Plan and Subject to Deductible and Coinsurance	
		Network Prev. Care Allowance, then Ded. &Coins.	Non-Network Subject to Ded. & Coins.		
TMJ/Orthognathic Surgery	Not Covered under Medical – see Dental	Not Covered under Medical – see Dental		Not Covered under Medical – see Dental	
Custom Shoe Inserts	Not Covered – see KanElect	Not Covered – see KanElect		Not Covered – see KanElect	
Allergy Testing	As approved by Primary Care Physician and Precertified by Health Plan, Subject to Office Visit Copayment	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Antigen Administration (desensitazation/treatment) Allergy Shots	As approved by Primary Care Physician and Subject to Office Visit Copayment	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Infertility Treatment (limited to testing & 3 attempts at artificial insemination per year)	As approved by Primary Care Physician and Precertified by Health Plan, Subject to Office Visit Copayment	Subject to Deductible and Coinsurance		Subject to Deductible and Coinsurance	
Gastric Surgery and Other Weight Loss Treatments	Not Covered – see KanElect	Not Covered – see KanElect		Not Covered – see KanElect	
Prescription Drug Benefits	Covered by AdvancePCS	Covered by AdvancePCS		Covered by AdvancePCS	
Dental Benefits	Covered by Delta Dental Plan of Kansas	Covered by Delta Dental Plan of Kansas		Covered by Delta Dental Plan of Kansas	

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While the Kansas State Employee Health Plan has standardized the core benefits of the HMOs and PPOs, some individual plan differences do exist. Where there are differences, this comparison chart is written in such a way that all plans meet or exceed the benefits shown. For example, some plans require prior authorization for a particular service and others do not—the prior authorization requirement is shown. The member should work with their physician and health plan to ensure that they understand the coverage that will be available for the services they desire.

HealthQuest – New Program Offerings

Health Risk Appraisal Credit and Disease Management Programs

The HealthQuest program has been providing a variety of health promotion programs to employees since 1988 including LIFELINE, Winterfit, smoking cessation, stress management, self-care, and HealthCheck.

This year HealthQuest is adding several new programs. Employees are being offered an opportunity to voluntarily participate in an individual Health Risk Appraisal/Health Screening program. Three new Disease Management programs are also being offered.

Health Risk Appraisal/Health Screening Credit

For Plan Year 2003 HealthQuest is offering an incentive to participate in the new health screening program that replaces HealthCheck. Members will receive a $5 per semi monthly ($120 a year) payroll deduction credit on their dental premium during Plan Year 2003. This credit replaces the non-tobacco user discount offered in Plan Year 2002 and is displayed on the dental rates page. **To participate in this program, employees must sign up during Open Enrollment in October 2002.**

The program consists of a health screening (HS) at specifically identified local medical plan provider or laboratory and includes tests for cholesterol, glucose, and various biometric measures. The on-line Health Risk Appraisal (HRA) component consists of a questionnaire assessing general health parameters and lifestyle behaviors. These two components give participants a snapshot of their health risks and possible areas for improvement.

The Health Screening results will be needed before going on-line to complete the HRA. The member will then enter the HS data into a secure web site and complete the HRA. A software program will analyze the data and provide the participant with a confidential, individualized report of the results and educational information about making healthy lifestyle changes to reduce their health risks.

Specific information about how to get the Health Screening will be sent prior to January 1, 2003 to those who sign up for the Health Risk Appraisal program.

Disease Management

HealthQuest is partnering with AdvancePCS, the State's Pharmacy Benefit Manager to add three disease management programs to its spectrum of services. These new programs will focus on identified areas of the Health Plan and will integrate pharmacy benefit, clinical services and patient support services into programs designed to help people achieve optimal health. AdvancePCS will administer a series of disease management programs entitled *"Building Better Health."* The goal of these programs is to assist people in maintaining or enhancing their health through self-care management and effective communication with their physician. Many of the patient interventions used in the *Building Better Health*

series include the use of condition or disease specific educational booklets, seasonal health reminder messages, medication cards, resource lists, telephonic outreach and other educational messaging. Some important facts to remember are:

- The programs are **totally voluntary**.
- The programs are completely confidential and no member personal medical information is shared with any State of Kansas agency.
- The programs are free to eligible members.
- The programs are a great way to become a more knowledgeable consumer of health services.

AdvancePCS will gear interventions towards physicians and patients in an effort to reinforce standards of physician practice, improve preventive care, increase communication between the patient and healthcare team and foster patient self-management skills.

Cardiovascular Risk Reduction

According to the Centers for Disease Control, over 60 million Americans have some form of cardiovascular disease (CVD). Moreover, CVD is the nation's number one killer for men and women among all racial and ethnic groups. In 2000, CVD cost the nation $215 billion in direct and indirect health care expenditures. Despite understanding the role of cholesterol management, only one fourth of patients recommended for cholesterol therapy are being treated, more than half discontinue use by the end of year one, and many are not treated to target levels.

Patient Medication Safety Program

Medication safety has always been a concern, but that concern is rising due to the increasing number of prescription, over-the-counter, and herbal medications that patients have available to them.

Depression Management

Depression is a serious and common illness that can be effectively treated. According to the National Institute of Mental Health, almost 19 million Americans suffer from a depression disorder each year. Depression can affect anyone, yet the risk is often greatest in people with chronic conditions where the morbidity and the rate of mortality are increased.

To sum it up, these Disease Management programs are intended to help members with chronic disease manage their care and improve their quality of life. More information about these and other health concerns is available to plan members through the Building Better Health web site. The identified programs will offer members with chronic conditions an opportunity to take the next step in managing their care.

HMO INFORMATION

All services require prior approval or referral by the participant's Primary Care Physician (PCP) except where noted otherwise.

All HMO's offered by the State of Kansas offer standardized benefits outlined in the Group Health Insurance Comparison chart located in this book. Each HMO has a unique certificate of coverage available for review on the website: **http://da.state.ks.us/ps/subject/benlink.htm**. To enroll for coverage in an HMO, the participant and all covered dependents must maintain primary residence within the service area for the plan selected. Refer to the Enrollment Eligibility Map for specific eligibility information.

Keys to Using HMO's

- **Employee should verify eligibility with the insurance provider and with the Primary Care Physician (PCP) before a PCP selection is made.**

- **Provider directories and certificates of coverage are available on the State of Kansas website: http://da.state.ks.us/ps/subject/benlink.htm.**

- **All medical services must be coordinated through each covered member's Primary Care Physician (PCP) or HMO plan.** This includes any treatment recommended by a specialist to whom the member has been previously referred.

- **Changes in PCP selection** will become effective the first of the month following notification to the HMO plan. **Changes must be made by contacting the HMO plan.**

- **The PCP is the first person the member should contact when health care is needed, either for preventive reasons or illness.** It is the PCP's responsibility to see that the member is seen in a timely manner and receives appropriate care. If there is a medical necessity for medical care by a provider other than the member's PCP, the PCP must authorize and coordinate this care. The member's PCP should make arrangements for a colleague to cover their practice when the PCP is unavailable. The covering physician can provide services or referrals when necessary and appropriate.

- **All referrals from the member's PCP to a specialist must be obtained PRIOR to the receipt of services.** The member's PCP will refer the member to a specialist participating with the HMO plan. If there is a medical reason for using a specialist that does not contract with the health plan, the member's PCP must seek authorization from the HMO plan before the referral is made.

- Women may visit an OB/GYN physician participating with their HMO plan for an annual **well woman exam** without a referral from their PCP. Women should verify that the OB/GYN physician is still participating with their HMO plan when scheduling their well woman exam.

- **All emergency room visits for emergency medical conditions** must be reported to the HMO plan within a specified period of time – usually 24 to 48 hours. In cases of life or limb threatening emergencies, the member should seek help immediately. For non-life or limb threatening situations, the member should call their PCP before seeking treatment.

- **Urgent care** or care needed on evenings, weekends, or holidays must be coordinated by the member's PCP or the covering physician. The PCP (or the covering physician) will be available 24 hours a day.

- **Claims for treatment of dental accidents/injuries** must first be submitted to the dental plan for payment of covered services. The member's PCP must refer for all specialty services subsequently eligible for coverage by the medical plan.

- **Out of area services** are limited to initial treatment of an accident or emergency. Routine or elective care is not covered outside the service area.

All non-emergency hospital admissions must be authorized in advance by the HMO plan.

COVENTRY HEALTH CARE (HMO)

Coventry Health Care is a fully insured Health Maintenance Organization (HMO) and is accredited by URAC for Health Utilization Management Standards. To enroll for coverage in Coventry Health Care, the member and all covered dependents must maintain primary residence within the Kansas City/Topeka service area or the Wichita/South Central Kansas service area. See the Enrollment Eligibility Map. Any covered member or dependent residing temporarily outside the enrollment area will be covered for emergency services only.

Mental Health/Substance Abuse benefits are coordinated by American Psych Systems (APS). The covered member or dependent seeking care should call APS (see number below). A referral from the member's PCP is not needed.

For additional information, refer to the HMO Information and the Medical Plans Comparison chart located in this booklet.

Mailing Address

Kansas City/Topeka Area:
Coventry Health Care of Kansas
1001 E. 101st Terrace, Suite 300
Kansas City, MO 64131

Wichita/South Central Area:
Coventry Health Care of Kansas
8301 East 21st Street North, Suite 300
Wichita, KS 67206

Customer Service Telephone Numbers

Kansas City/Topeka Area	800-969-3343
Wichita/South Central Area	866-320-0697
APS	800-752-7242
FirstHelp	800-622-9528 (for emergency room or urgent care)

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

COVENTRY
Health Care of Kansas, Inc.

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

COVENTRY HEALTH CARE (HMO)

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

	Full-Time Salary Range1 Earning < $25,000 per year	
1	Member Only	$ 3.98
2	Member & Spouse	$ 103.53
3	Member & Child(ren)	$ 83.62
4	Member & Spouse & Child(ren)	$ 183.17
	Full-Time Salary Range 2 Earning $25,000< > $44,500 per year	
1	Member Only	$ 9.19
2	Member & Spouse	$ 108.74
3	Member & Child(ren)	$ 88.83
4	Member & Spouse & Child(ren)	$ 188.38
	Full-Time Salary Range 3 Earning => $44,500 per year	
1	Member Only	$ 14.24
2	Member & Spouse	$ 113.79
3	Member & Child(ren)	$ 93.88
4	Member & Spouse & Child(ren)	$ 193.43
	Part-Time Any salary level	
1	Member Only	$ 41.28
2	Member & Spouse	$ 154.23
3	Member & Child(ren)	$ 131.63
4	Member & Spouse & Child(ren)	$ 244.59
	Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:	
1	Member Only	$ 153.16
2	Member & Spouse	$ 306.31
3	Member & Child(ren)	$ 275.68
4	Member & Spouse & Child(ren)	$ 428.83

COVENTRY
Health Care of Kansas, Inc.

MID AMERICA HEALTH (HMO)

Mid America Health is a fully insured Health Maintenance Organization (HMO). To enroll for coverage in Mid America Health, the member and all covered dependents must maintain primary residence within the Mid America Health enrollment area. See the Enrollment Eligibility Map. Any covered member or dependent residing temporarily outside the enrollment area will be covered for emergency services only.

For additional information, refer to the HMO Information and the Medical Plans Comparison chart located in this booklet.

Mailing Address

Mid America Health
8320 Ward Parkway
Kansas City, MO 64114

Customer Service Telephone Numbers

Outside K.C. area 800-632-4761
In Kansas City 816-460-4655
Mid America HealthLine – see employee ID card for the toll-free number.

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

MID AMERICA HEALTH (HMO)

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 3.92
2	Member & Spouse	$ 102.02
3	Member & Child(ren)	$ 82.40
4	Member & Spouse & Child(ren)	$ 180.50
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 9.06
2	Member & Spouse	$ 107.15
3	Member & Child(ren)	$ 87.53
4	Member & Spouse & Child(ren)	$ 185.63
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 14.04
2	Member & Spouse	$ 112.13
3	Member & Child(ren)	$ 92.51
4	Member & Spouse & Child(ren)	$ 190.61
Part-Time Any salary level		
1	Member Only	$ 40.67
2	Member & Spouse	$ 151.98
3	Member & Child(ren)	$ 129.72
4	Member & Spouse & Child(ren)	$ 241.02
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 150.92
2	Member & Spouse	$ 301.84
3	Member & Child(ren)	$ 271.66
4	Member & Spouse & Child(ren)	$ 422.58

PREFERRED PLUS OF KANSAS (HMO)

Preferred Plus of Kansas, Inc. (PPK) is a fully insured Health Maintenance Organization (HMO). PPK is accredited by the Joint Commission on Accreditation of Healthcare Organizations. To enroll for coverage in PPK, the member and all covered dependents must maintain primary residence within the PPK enrollment area in south central Kansas. See the Enrollment Eligibility Map. Any covered member or dependent residing temporarily outside the enrollment area will be covered for emergency services only.

For additional information, refer to the HMO Information and the Medical Plans Comparison chart located in this booklet.

Mailing Address

Preferred Plus of Kansas
8535 E. 21st Street North
Wichita, KS 67206

Customer Service Telephone Numbers:

Toll free:	866-618-1691
In Wichita:	316-609-2555
Behavioral Health Services	316-609-2541 in Wichita 866-338-4281 in all other areas

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

Preferred Health Systems

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PREFERRED PLUS OF KANSAS (HMO)

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 3.88
2	Member & Spouse	$ 100.93
3	Member & Child(ren)	$ 81.52
4	Member & Spouse & Child(ren)	$ 178.56
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 8.96
2	Member & Spouse	$ 106.00
3	Member & Child(ren)	$ 86.59
4	Member & Spouse & Child(ren)	$ 183.64
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 13.88
2	Member & Spouse	$ 110.93
3	Member & Child(ren)	$ 91.52
4	Member & Spouse & Child(ren)	$ 188.57
Part-Time Any salary level		
1	Member Only	$ 40.24
2	Member & Spouse	$ 150.35
3	Member & Child(ren)	$ 128.32
4	Member & Spouse & Child(ren)	$ 238.43
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 149.30
2	Member & Spouse	$ 298.60
3	Member & Child(ren)	$ 268.74
4	Member & Spouse & Child(ren)	$ 418.04

PREMIER BLUE (HMO)

Premier Blue is a fully insured Health Maintenance Organization (HMO) and is accredited by URAC for Health Utilization Management Standards. To enroll for coverage in Premier Blue, the member and all covered dependents must maintain primary residence within the Premier Blue enrollment area. See Enrollment Eligibility Map. Any covered member or dependent residing temporarily outside the enrollment area will be covered for emergency services only.

Mental Health/Substance Abuse benefits are coordinated by Health Management Strategies (HMS). The covered member or dependent seeking care should call HMS for authorization before services are received (see numbers below). A referral from the member's PCP is not needed.

For additional information, refer to the HMO Information and the Medical Plans Comparison chart located in this booklet.

Mailing Address

Premier Blue
P.O. Box 3518
Topeka, KS 66601-3518

Customer Service Telephone Numbers:

Toll free:	800-332-0028
In Topeka:	291-4010

Health Management Strategies

Toll free:	800-952-5906
In Topeka:	233-1165

Customer service representatives are available Monday through Friday from 8:00 a.m. – 5:00 p.m. (CST).

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

PremierBlue

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PREMIER BLUE (HMO)

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 3.86
2	Member & Spouse	$ 100.33
3	Member & Child(ren)	$ 81..3
4	Member & Spouse & Child(ren)	$ 177.50
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 8.90
2	Member & Spouse	$ 105.37
3	Member & Child(ren)	$ 86.08
4	Member & Spouse & Child(ren)	$ 182.54
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 13.80
2	Member & Spouse	$ 110.27
3	Member & Child(ren)	$ 90.97
4	Member & Spouse & Child(ren)	$ 187.44
Part-Time Any salary level		
1	Member Only	$ 40.00
2	Member & Spouse	$ 149.45
3	Member & Child(ren)	$ 127.56
4	Member & Spouse & Child(ren)	$ 237.01
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 148.41
2	Member & Spouse	$ 296.82
3	Member & Child(ren)	$ 267.14
4	Member & Spouse & Child(ren)	$ 415.55

PremierBlue

PPO Information

Two Preferred Provider Organization plans are offered:

Kansas Prefer, using the Private HealthCare Systems (PHCS) network, is a self-insured PPO administered by Harrington Benefit Services.

PHSIC PPO (Preferred Health Systems Insurance Company) is a fully insured plan.

The two PPO plans have a standardized benefit structure that is outlined in the Comparison Chart.

Keys to Using PPO's

- **Provider Directories and Certificates of Coverage (insured plans) or Benefit Descriptions (self-insured plans) are available on the State of Kansas Web Site:** http://da.state.ks.us/ps/subject/benlink.htm

- **All Claims are paid based on the contracting status of the provider of service at the time the service is performed.**

- **When discussing complex procedures with the physician**, be sure to ask for names of any ancillary providers (i.e. anesthesiologist, assistant surgeon, laboratory, etc) that may be recommended. This allows the member to check their contracting status before any services are performed.

- **Members may choose to utilize a non-contracting provider. However, these providers may charge whatever they choose.** The plan will pay based upon a maximum allowed charge for the procedures, which could result in additional out-of-pocket expenses for the member. Therefore, ask if the provider will accept the plan's allowance as payment in full. Explain that you are willing to pay the higher coinsurance amounts, but would like the assurance that there will be no surprises over and above the plan allowance. (Providers won't always agree, but at least the member will know this before the service is provided.)

- The PPO plans feature a ***Preventive Care Service Allowance*** of $300 per person per year for specified wellness services. This allowance applies only for services provided by network or contracting providers. Services provided by non-contracting providers will be subject to deductible and coinsurance.

- Claims for the treatment of dental accidents/injuries must first be submitted to the dental plan for payment of covered services. Services covered by the dental plan are not eligible for reimbursement through the medical plan.

KANSAS PREFER – PPO

Kansas Prefer is a self-insured Preferred Provider Organization plan. The state utilizes the services of a third party administrator, Harrington Benefit Services for claims processing and customer service. All employee and dependents are eligible to enroll.

Provider contracting, network development and utilization review are all handled by Private HealthCare Systems (PHCS). PHCS has earned four (4) endorsements of quality from two independent and nationally recognized organizations: National Committee for Quality Assurance (NCQA) and URAC also known as the American Accreditation HealthCare Commission.

Members do not need to designate a Primary Care Physician (PCP). The PHCS network includes over 362,000 professional providers and 1,580 facilities nationwide. In the state of Kansas, the network includes over 1,580 professional providers and 59 facilities with continued growth planned. Members are also free to see other non-participating or non-network providers, but need to understand the benefit levels are different and that member responsibilities (such as copays, deductibles and coinsurance) are different.

Benefits are described in the Comparison Chart and the Benefit Description is posted on the web at http://da.state.ks.us/ps/subject/benlink.htm.

Mailing Address

Kansas Prefer
P.O. Box 268941
Oklahoma City, OK 73126-8941

Customer Services Telephone Number

Toll free: 800-882-3639

Customer Services representatives are available Monday through Friday 8:00 a.m. – 5:00 p.m. (CST).

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

PHCS PRIVATE HEALTHCARE SYSTEMS® Harrington

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

KANSAS PREFER

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 4.13
2	Member & Spouse	$ 107.48
3	Member & Child(ren)	$ 86.81
4	Member & Spouse & Child(ren)	$ 190.15
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 9.54
2	Member & Spouse	$ 112.88
3	Member & Child(ren)	$ 92.21
4	Member & Spouse & Child(ren)	$ 195.56
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 14.79
2	Member & Spouse	$ 118.13
3	Member & Child(ren)	$ 97.46
4	Member & Spouse & Child(ren)	$ 200.80
Part-Time Any salary level		
1	Member Only	$ 42.85
2	Member & Spouse	$ 160.10
3	Member & Child(ren)	$ 136.65
4	Member & Spouse & Child(ren)	$ 253.91
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 158.99
2	Member & Spouse	$ 317.98
3	Member & Child(ren)	$ 286.18
4	Member & Spouse & Child(ren)	$ 445.17

PHCS PRIVATE HEALTHCARE SYSTEMS®
Harrington

PREFERRED HEALTH SYSTEMS INSURANCE COMPANY (PHSIC) – PPO

Preferred Health Systems Insurance Company (PHSIC) is a fully insured Preferred Provider Organization with a local network located primarily within the State of Kansas. All employees and their dependents are eligible to enroll in the PHSIC PPO plan.

Members do not need to designate a Primary Care Physician (PCP). The PHSIC network includes nearly 4,000 providers in an area that covers most of the state. Members are also free to see other non-participating or non-network providers, but need to understand the benefit levels are different and that member responsibilities (such as copays, deductibles and coinsurance) are different.

Benefits are described in the Comparison Chart and the Certificate of Insurance is posted on the web at http://da.state.ks.us/ps/subject/benlink.htm.

Mailing Address

Preferred Health Systems Insurance Company
8535 East 21St Street North
Wichita, KS 67206

Customer Service Telephone Numbers

Toll free:	866-618-1691
In Wichita:	316-609-2555

Member Service representatives are available Monday through Friday 8:00 a.m. – 5:00 p.m. (CST).

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

Preferred Health Systems

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

PREFERRED HEALTH SYSTEMS INSURANCE COMPANY (PHSIC) PPO

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 4.53
2	Member & Spouse	$ 117.84
3	Member & Child(ren)	$ 95.18
4	Member & Spouse & Child(ren)	$ 208.49
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 10.46
2	Member & Spouse	$ 123.77
3	Member & Child(ren)	$ 101.10
4	Member & Spouse & Child(ren)	$ 214.41
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 16.21
2	Member & Spouse	$ 129.52
3	Member & Child(ren)	$ 106.86
4	Member & Spouse & Child(ren)	$ 220.17
Part-Time Any salary level		
1	Member Only	$ 46.98
2	Member & Spouse	$ 175.54
3	Member & Child(ren)	$ 149.83
4	Member & Spouse & Child(ren)	$ 278.39
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 174.32
2	Member & Spouse	$ 348.64
3	Member & Child(ren)	$ 313.78
4	Member & Spouse & Child(ren)	$ 488.10

Preferred Health Systems

Managed Indemnity Information

Kansas Choice is a self-insured Managed Indemnity Plan administered by Blue Cross Blue Shield of Kansas. Benefits are outlined in summary fashion on the Comparison Chart in this booklet.

Keys to Using the Kansas Choice Plan

- The Provider Directories and Benefit Description are available through the State of Kansas Web Site: http://da.state.ks.us/ps/subject/benlink.htm
- Most providers within the service area are part of the network. The service area is the state of Kansas excluding Johnson and Wyandotte Counties.
- The plan utilizes the Blue Card PPO network of providers outside the service area including Johnson and Wyandotte counties.
- Links to the out-of-area directories (such as surrounding states) are available on the web site. Scroll down the page to read and follow the directions to access the directory wanted.
- Claims for the treatment of dental accidents/injuries must first be submitted to the dental plan for payment of covered services. Services covered by the dental plan are not eligible for reimbursement through the medical plan.

KANSAS CHOICE – Managed Indemnity Plan

Kansas Choice is a self-funded Managed Indemnity Plan. Blue Cross Blue Shield of Kansas is a Third Party Administrator (TPA) contracting with the Kansas State Employees Health Care Commission for the administration of the Kansas Choice product. Blue Cross Blue Shield is responsible for claims processing and customer service, network management and utilization review.

All employees and their dependents are eligible to enroll in the Kansas Choice plan. There is a network of providers in Kansas as well as throughout the United States. Benefits are described on the Comparison Chart and the Benefit Description is posted on the web at **http://da.state.ks.us/ps/subject/benlink.htm**.

There are two levels of benefits in the Kansas Choice Plan. Claims payment is based upon the contracting status of the service provider.

Network Providers: In the Blue Cross Blue Shield of Kansas Service Area, most providers participate in the network. For the Kansas City Metropolitan area, including Johnson and Wyandotte counties, network providers are those which contract as Preferred Care Blue Providers with Blue Cross Blue Shield of Kansas City. In all other locations, network providers are those which contract with the Blue Card PPO network. Links to all provider directories are available through the web site above. The initial link is to the local, Blue Cross Blue Shield of Kansas directory, with further links to the Kansas City plan and the national Blue Card network provided on the same web page.

Non-Network Providers: The Kansas Choice program allows a member to seek care from any provider they choose. When selecting a non-network provider, the member will be responsible for the deductible and coinsurance levels specified for non-network providers in the comparison chart as well as any amounts above the plan allowances.

Special Note: There are different deductibles and coinsurance maximums for network and non-network services. Deductibles applied to network care do not credit toward non-network benefits.

Mailing Address

Kansas Choice
Blue Cross Blue Shield of Kansas
1133 SW Topeka Blvd
Topeka, KS 66629-0001

Customer Service Telephone Numbers

Toll free: 800-332-0307
In Topeka: 785-291-4185

Customer service representatives are available Monday through Friday from 8:00 a.m. – 5:00 p.m. (CST).

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

KANSAS CHOICE

Employee's Cost of Coverage

Rates listed below are for Medical and Prescription Drug coverage per semi-monthly (i.e. 24) deduction period. Rates for Dental and Vision coverage are listed separately in this book.

Full-Time Salary Range1 Earning < $25,000 per year		
1	Member Only	$ 4.31
2	Member & Spouse	$ 112.03
3	Member & Child(ren)	$ 90.49
4	Member & Spouse & Child(ren)	$ 198.21
Full-Time Salary Range 2 Earning $25,000< > $44,500 per year		
1	Member Only	$ 9.94
2	Member & Spouse	$ 117.67
3	Member & Child(ren)	$ 96.12
4	Member & Spouse & Child(ren)	$ 203.85
Full-Time Salary Range 3 Earning => $44,500 per year		
1	Member Only	$ 15.41
2	Member & Spouse	$ 123.14
3	Member & Child(ren)	$ 101.59
4	Member & Spouse & Child(ren)	$ 209.31
Part-Time Any salary level		
1	Member Only	$ 44.66
2	Member & Spouse	$ 166.89
3	Member & Child(ren)	$ 142.44
4	Member & Spouse & Child(ren)	$ 264.67
Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:		
1	Member Only	$ 165.73
2	Member & Spouse	$ 331.46
3	Member & Child(ren)	$ 298.31
4	Member & Spouse & Child(ren)	$ 464.04

AdvancePCS

AdvancePCS is the Pharmacy Benefit Manager (PBM) administering the self-insured prescription benefit plan offered to members of the Kansas State Employees Health Insurance Plan. With a network of over 65,000 pharmacies nationwide, AdvancePCS serves 75 million people and manages approximately $28 billion in annual prescription drug spending.

For the approximately 90,000 State of Kansas plan participants, AdvancePCS processes an average of 32,000 claims each week providing more than $952,000 in benefits during that time period.

AdvancePCS establishes the drug formulary in a five tier prescription drug component of the Health Plan. Additional information concerning the benefit levels, copays and coinsurance are contained in the following page.

Mailing Address

AdvancePCS, Inc.
P.O. Box 853901
Richardson, TX 75085-3901

Customer Service Telephone Numbers

Toll free:	800-294-6324
TDD:	800-863-5488

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

Prescription benefits are included with all medical plans and the cost of this program is incorporated into the medical plan rates.

The full Benefit Description, preferred drug list (formulary) and other information related to the Prescription Benefit Plan are posted on the web site: http//da.state.ks.us/ps/benlink.htm. The preferred drug list (formulary) is updated throughout the year.

The Kansas State Employees Prescription Benefit Plan is a five tier program designed to encourage plan members to partner with their physicians in choosing cost effective medications when needed for the treatment of illness or injury. The AdvancePCS Pharmacy and Therapeutics Committee manages the drug formulary and assists the state in determining the appropriate tiers for the level of coverage.

		Member Pays
Tier One	Generic Drugs	20% co-insurance
Tier Two	Preferred Brand Name Drugs	30% co-insurance
Tier Three	Special Case Medications[1]	$70 co-pay per prescription fill
Coinsurance/Copay	Tiers One, Two & Three only	$2,400 per person per year
Maximum		
Tier Four	Non-Preferred Brand Name Drugs	50% coinsurance
Tier Five	Lifestyle Medications[2]	100% of the discounted price

Initial fill of any prescription is limited to one standard unit of therapy or a 30-day supply, whichever is less. Refills may be obtained after 75% of the previous fill has been consumed. Medications may be refilled for two standard units of therapy or up to a 60-day supply if the prescription was written for a 60-day supply and the previous fill was within 90-days.

AdvancePCS offers a MAIL-ORDER pharmacy with lower cost and free delivery for members.

SpecialtyRx

A new feature to the benefit plan will be the addition of the SpecialtyRx program which focuses on patients who utilize medications in tier three – Special Case medications. The program will offer members a convenient source for these high cost injectibles and supplies, lower potential drug-to-drug interactions and improved therapy compliance.

Patients selected to participate in the SpecialtyRx program will have access to pharmacists or nurses 24 hours per day, 7 days a week. These clinicians specialize in the management of chronic conditions. Individualized care plans are developed for patient-specific conditions and involve the physician, case manager, clinical pharmacist, nurse and patient in a coordinated and monitored course of treatment. Of course, a patient may opt-out of the program if they desire.

Note: It is the treating physician (and the patient), not the health care plan or the employer, who determines the course of medical treatment. Whether or not the plan will cover all or part of the treatment cost is secondary to the decision of what the treatment should be.

[1] Very high-cost medications used to treat generally life-threatening conditions.

[2] Medications used primarily to enhance lifestyle rather than treat an illness or condition.

GENERAL DENTAL INFORMATION

All State of Kansas members in health plans with single coverage are also enrolled in the dental program. A member may elect to provide dental coverage for all dependents who are enrolled in medical coverage through the State of Kansas group.

If a member or covered dependent is contemplating services that cost $200.00 or more, the benefits should be predetermined by the dental plan so that the member will know in advance how much will be covered.

For treatment due to accidental injury, the dental plan will be primary. Only those services not covered by the dental plan may be submitted to the member's medical plan subject to any requirements of that plan. No service will be covered by both the dental and the medical plan.

All members will be able to reduce the premium for dental coverage by participating in the Health Risk Appraisal. The credit for participation in the HRA replaces the non-tobacco user discount offered in previous years. Additional information is located in the HealthQuest section of this booklet.

DELTA DENTAL PROGRAM

Delta Dental Plan of Kansas contracts with the State of Kansas to provide dental services on a self-insured basis. Delta Dental processes covered dental claims which are then funded by the State of Kansas. Most Kansas dentists participate with Delta Dental. If the member has any questions concerning whether or not their dentist is a participating dentist with Delta Dental, the member should ask their dentist, check the provider website, http://da.state.ks.us/ps/subject/benlink.htm or contact Delta Dental Plan of Kansas.

Sometimes more than one procedure is available which, according to accepted standards of dental practice, would restore the tooth to function. If a more expensive service or benefit is selected than is needed, the plan will pay the applicable percentage of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. The remainder of the fee will be the responsibility of the participant.

Regular (Premier) Network

The member may make an appointment with the dentist of their choice and tell the dentist that they are covered by Delta Dental Plan of Kansas. The dentist may complete the necessary claim form and file the claim with Delta Dental for the member. Delta Dental will make payment directly to the dental provider. The member will only be charged for the specific coinsurance or for any services not covered by the plan.

DPO Network

In addition to the regular dental network, Delta Dental also offers the Delta Preferred Option (DPO). The DPO is a group of participating dental providers who have agreed to a reduced fee for providing dental services. However, the DPO network is limited to the more urban areas of the State of Kansas. A separate participating DPO provider list is provided by Delta Dental.

Members who are enrolled for dental coverage will not be required to enroll specifically in the DPO to obtain the higher level of benefits and improved discounts. All members of the Delta Dental program may use the DPO providers whenever desired. Benefits will be determined by whether or not a DPO provider is used for services. Providers can now be verified online.

DELTA DENTAL PROGRAM

Non Network

A dentist who does not contract with Delta Dental may require the member to pay their bill at the time of service. The member will then need to file the claim with Delta Dental. Delta Dental will process the claim and mail the appropriate payment to the member. The member will receive the applicable percentage based on the lesser of the actual fee charged or the customary fee as determined from filed fees of all the participating dentists.

Mailing Address

Delta Dental Plan of Kansas
P.O. Box 49198
Wichita, KS 67201-9198

Customer Service Telephone Numbers

Toll Free 800-234-3375
In Wichita 316-264-4511

Website Address

http://da.state.ks.us/ps/subject/benlink.htm

DELTA DENTAL®
Delta Dental Plan of Kansas

DELTA DENTAL PROGRAM BENEFITS

The percentage co-payments reflect what is paid by the administrator of the dental program, subject to the conditions of the coverage.

DPO Panel	Non-DPO Panel	
100%	100%	**DIAGNOSTIC AND PREVENTIVE SERVICES:** Oral examinations twice per plan year Diagnostic x-rays: bitewings twice per plan year for dependents under age 18 and once per plan year for adults age 18 and over Full mouth x-rays once each five years Prophylaxis/cleanings (including periodontal maintenance) twice per plan year Topical fluoride twice per plan year for dependent children under age 19 Space maintainers only for the premature loss of primary molars and only for dependent children under the age of 9 Sealants are covered for dependent children under age 17 and only when applied to permanent molars with no caries (decay) or restorations on the occlusal surface. Sealants are limited to one per four years
100%	100%	**ANCILLARY:** Provides for visits to the dentist for the emergency relief of pain.
80%	60%	**REGULAR RESTORATIVE DENTISTRY:** Provides amalgam (silver) restorations; composite (white) resin restorations on anterior (front) teeth; and stainless steel crowns for dependents under age 12.

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The following procedures are subject to a $35 deductible per person per calendar year not to exceed an annual family deductible of $105:

80%	60%	**ORAL SURGERY:** Provides for extractions and related oral surgical procedures performed by the dentist including pre- and post-operative care.
80%	60%	**ENDODONTICS:** Includes procedures for root canal treatments and root canal fillings.
80%	60%	**PERIODONTICS:** Includes procedures for the treatment of diseases of the gums and bone supporting the teeth.
50%	50%	**SPECIAL RESTORATIVE DENTISTRY:** When teeth cannot be restored with a filling material listed in Regular Restorative Dentistry, provides for gold restorations and individual crowns.
50%	50%	**PROSTHODONTICS:** Bridges, partial and complete dentures, including repairs and adjustments.
50%	50%	**TMJ:** Treatment is limited to specific non-surgical procedures involving Temporomandibular Joint Dysfunction. **A treatment plan must be pre-authorized by Delta Dental.**

ANNUAL MAXIMUM: The maximum paid by the plan for the above treatments is

$1,500 per person per calendar year.

DELTA DENTAL PROGRAM

ORTHODONTIC COVERAGE

Procedures for orthodontic appliances and treatment, including both interceptive and corrective, are covered at 50% only when provided by a Delta Dental Plan participating dentist. Orthodontic treatments are not subject to a deductible and have a $1,000 per person lifetime maximum. The maximum for orthodontic services does not apply to the regular annual maximum for other covered services. To be covered, orthodontic treatment must start after the effective date of dental coverage.

Employee's Cost of Coverage

Rates listed below are for Delta Dental coverage only per semi-monthly (i.e., 24) deduction period. See rate charts for each medical provider for additional medical and prescription drug rates.

	HRA Member	
1	Member Only	$ 0.00
2	Member & Spouse	$ 6.66
3	Member & Child(ren)	$ 5.33
4	Member & Spouse & Child(ren)	$ 11.99
	Non-HRA Member	
1	Member Only	$ 5.00
2	Member & Spouse	$ 11.66
3	Member & Child(ren)	$ 10.33
4	Member & Spouse & Child(ren)	$ 16.99
	Part Time - HRA Member	
1	Member Only	$ 2.56
2	Member & Spouse	$ 8.84
3	Member & Child(ren)	$ 10.47
4	Member & Spouse & Child(ren)	$ 18.84
	Part Time - Non-Member	
1	Member Only	$ 7.56
2	Member & Spouse	$ 13.84
3	Member & Child(ren)	$ 15.47
4	Member & Spouse & Child(ren)	$ 23.48
	Note: the State Contributes the difference between the employee's cost and the total premium. Total semi-monthly premium is as follows:	
1	Member Only	$ 10.25
2	Member & Spouse	$ 20.50
3	Member & Child(ren)	$ 18.45
4	Member & Spouse & Child(ren)	$ 28.70

Note: These charts reflect different rates depending on whether the employee chooses to participate in a Health Risk Appraisal and receive a $5 credit per semi-monthly payroll deduction.

SUPERIOR VISION SERVICES, INC.

Superior Vision Services Basic and Enhanced plans are fully insured voluntary vision programs. Employees may elect to enroll themselves and any eligible dependents in one of the vision programs, whether or not the employee or dependents are enrolled in State of Kansas medical coverage. However, if dependent vision coverage is selected and dependent children are also enrolled in the medical plan, the dependent children enrolled in vision must match those enrolled in the medical plan. Enrollment even on an after-tax basis cannot be changed during the Plan Year unless due to either a newly eligible dependent or to a dependent becoming ineligible.

Network Providers – How Superior Vision Service Works

To obtain vision care services under the Basic or Enhanced Plans, the member should contact a Superior Vision network provider. Identify yourself to the network provider as a member of the Superior Vision Plan. You can use your ID card for this purpose or simply give the provider your name, indicate you are a member with the State of Kansas and your ID number. The provider will contact Superior Vision to verify your eligibility and plan coverage, and obtain an authorization number. All covered family members can use the ID card provided to you. The network provider handles all claims and paperwork. Superior Vision will pay the network provider for covered services and materials. The patient is responsible for any copayments and any additional costs resulting from cosmetic options, or non-covered services and materials selected.

If the member has medical coverage through the State of Kansas, the medical plan will cover one routine eye exam each year. To coordinate benefits with the medical plan, the Superior Vision provider will also need the name of the medical plan and the member's plan identification number. To maximize benefits, members need to make sure that their chosen provider is a network provider for both the vision and medical plan.

Members have the freedom to purchase lenses, frames, contacts and other services from either a Superior Vision doctor providing the eye exam or any other Superior Vision network provider. For member convenience, the Superior Vision provider network includes optometrists, ophthalmologists and optical chain stores.

Non-Network Providers – How Superior Vision Works

Before a member receives services from a non-network provider, the member should contact Superior Vision Member Services Department at **1-800-507-3800** to receive an authorization number. By doing so you may be assured of your eligibility and reimbursement for eligible costs. After receiving services, the member is responsible for paying the provider in full and submitting itemized receipts along with the authorization report to Superior Vision at the address listed below for reimbursement. You will be reimbursed according to the reimbursement schedule for non-network providers. It is important to note that the reimbursement schedule does not guarantee full payment and Superior Vision cannot guarantee patient satisfaction when services are received from a non-network provider.

Superior Vision's Additional Value
Discounts on additional eyewear
Discounts are available for additional eyewear purchases. The discounts range from 10% to 30% and are available at providers identified in the provider directory with a "DP".
Discounts on refractive surgeries such as LASIK, RK and PRK
Providers listed in the provider directory with the "RF" designation will provide Superior Vision members with a discount of 20% on refractive surgeries.

BASIC PLAN

For additional information regarding Superior Vision as well as information on provider locations you can visit the website for Superior Vision at:
http://da.state.ks.us/ps/subject/benlink.htm

Mailing address

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Customer Service Telephone Number

Toll free: 800-507-3800

STATE OF KANSAS BASIC PLAN	
Semi-Monthly Rates	**Amount**
Employee Only	$2.13
Employee + Spouse	$4.26
Employee + Child(ren)	$3.84
Employee + Family	$5.97
Co-pay	**Amount**
Eye Exam	$50.00
Materials (Eyeglasses, no copay on contact lenses)	$25.00

Benefit Type	Frequency Of Benefit	Benefit Amount In-Network	Benefit Amount Out-of-Network*
Eye Exam, M.D.	12 months	Subject to exam Copay then covered in full	Up to $38.00
Eye Exam, O.D.	12 months	Subject to exam Copay then covered in full	Up to $38.00
Single Vision, Pair	12 months	Subject to materials Copay then covered in full	Up to $31.00
Bifocal, Pair	12 months	Subject to materials Copay then covered in full	Up to $51.00
Trifocal, Pair	12 months	Subject to materials Copay then covered in full	Up to $64.00
Lenticular, Pair	12 months	Subject to materials Copay then covered in full	Up to $80.00
Frame	12 months	Subject to materials Copay then covered up to $100 Retail*	Up to $45.00
Contact Lenses, Medically Necessary	12 months	Covered in Full	Up to $210 retail
Contact Lenses, Elective-Cosmetic	12 months	Up to $150 retail*	Up to $105 retail

* The insured is responsible for paying any charges over the allowance.
Members can use either the contact lens benefit or the eyeglass benefit but not both in the same benefit period.
Out-of-Network Copay amount(s) is deducted from the allowance at the time of reimbursement.
Covered lenses are standard glass or plastic (CR39), clear

Superior Vision Services, Inc.

ENHANCED PLAN

For additional information regarding Superior Vision as well as information on provider locations you can visit the website for Superior Vision at:
http://da.state.ks.us/ps/subject/benlink.htm

Mailing address

Superior Vision Services, Inc.
P.O. Box 967
Rancho Cordova, CA 95741

Customer Service Telephone Number

Toll free: 800-507-3800

STATE OF KANSAS ENHANCED PLAN Includes Scratch Coat, UV Coat & Standard Progressive Power Lenses	
Semi-Monthly Rates	**Amount**
Employee Only	$3.32
Employee + Spouse	$6.64
Employee + Child(ren)	$5.98
Employee + Family	$9.30
Co-pay	**Amount**
Eye Exam	$50.00
Materials (Eyeglasses, no co-pay on contact lenses)	$25.00

Benefit Type	Frequency Of Benefit	Benefit Amount In-Network	Benefit Amount Out-of-Network*
Eye Exam, M.D.	12 months	Subject to exam Copay then covered in full	Up to $38.00
Eye Exam, O.D.	12 months	Subject to exam Copay then covered in full	Up to $38.00
Single Vision, Pair	12 months	Subject to materials Copay then covered in full	Up to $31.00
Bifocal, Pair	12 months	Subject to materials Copay then covered in full	Up to $51.00
Trifocal, Pair	12 months	Subject to materials Copay then covered in full	Up to $64.00
Lenticular, Pair	12 months	Subject to materials Copay then covered in full	Up to $80.00
Standard Progressive lens, Pair	12 months	Subject to materials Copay then Standard lens covered in full	Not covered
Scratch Coat	12 months	Covered in Full	Not covered
UV Coat	12 months	Covered in Full	Not covered
Frame	12 months	Subject to materials Copay then covered up to $100 Retail*	Up to $45.00
Contact Lenses, Medically Necessary	12 months	Covered in Full	Up to $210 retail
Contact Lenses, Elective-Cosmetic	12 months	Up to $150 retail*	Up to $105 retail

* The insured is responsible for paying any charges over the allowance.
Members can use either the contact lens benefit or the eyeglass benefit but not both in the same benefit period.
Out-of-Network Copay amount(s) is deducted from the allowance at the time of reimbursement.
Covered lenses are standard glass or plastic (CR39), clear

Superior Vision Services, Inc.

HEARING IMPROVEMENT PROGRAM (K-SHIP)

K-SHIP is a hearing improvement program utilizing the Hearing and Speech Departments at participating universities. It is an opportunity for employees and their families to receive a discount on certain hearing services from the Hearing and Speech Departments of:

- Fort Hays State University
- Kansas State University
- University of Kansas
- University of Kansas Medical Center
- Wichita State University

There is no premium or special enrollment associated with this value-added benefit.

Services include hearing evaluations and testing as well as hearing testing required to determine the need for hearing aids. Hearing evaluations may be eligible for coverage under a health plan. To maximize benefit options, be sure to contact the plan sponsor university and ask about coverage. If enrolled in HMO coverage, obtain a referral from the member's primary care physician before obtaining services.

Employees who are enrolled in the Health Plan and their covered family members are eligible to receive a ten- percent discount off the cost of hearing evaluation and testing services. Members do not have to apply for coverage or fill out any forms to be eligible for the discount. Simply tell the clinic you are a State of Kansas health plan member at the time appointment is made. Members will be asked to show their prescription drug card at the appointment to verify eligibility. Contact information is available at:
http://da.state.ks.us/ps/subject/oekship.htm

Pretax Premium Option

Before enrolling in the KanElect Pretax Premium Option or KanElect Flexible Spending Accounts Program, employees should refer to the additional enrollment information in this booklet or in the Employee Benefits Guide at the following website:

State of Kansas Website Address: http://da.state.ks.us/ps/benefits.htm

KanElect Pretax Premium Option is an Internal Revenue Code, Section 125 plan and is offered by the State of Kansas for the benefit of its employees. If an employee enrolls in Group Health Insurance coverage through the State of Kansas, they may elect to participate in the Pretax Premium Option. By selecting the pretax option, an employee reduces their taxable income by the amount of the cost of their health insurance coverage. This will reduce the amount of income tax required to be paid by the employee.

Non-participation means that the employee will pay for the cost of the Health Plan coverage on an after-tax basis.

Flexible Spending Accounts

The State of Kansas offers KanElect Flexible Spending Accounts. KanElect is an Internal Revenue Code, Section 125 plan. It allows the employee to pay for qualified unreimbursed health care expenses and dependent day care expenses with pretax dollars.

KanElect Options

The KanElect program offers two flexible spending account plans:

Health Care Flexible Spending Account—allows an enrolled employee to use pretax earnings to pay for certain incurred medical expenses allowed by the IRS but not reimbursed by medical, dental, vision or prescription drug insurance. Long Term Care insurance premiums and other premiums are not reimbursable under Flexible Spending accounts.

Dependent Care Flexible Spending Account—allows an enrolled employee to be reimbursed with pretax earnings for work-related dependent day-care expenses.

Enrollment

Employees who elect to participate in either the Health Care Flexible Spending or Dependent Care Flexible Spending Account(s) in Plan Year 2003 must do so via AKSESS. If currently enrolled in a flexible spending account for 2002, participation will end on December 31, 2002. **New enrollment is required for participation in Plan Year 2003.** Eligible employees may enroll in the KanElect program and include expenses for any eligible tax dependent even if they are not enrolled in the State's Health Plan.

Open Enrollment elections for flexible spending accounts for 2003 will become effective on January 1, 2003. Eligible expenses are only those incurred from January 1, 2003 through December 31, 2003.

How Much to Deposit

The minimum and maximum amounts eligible for deposit per semi-monthly deduction period are:

Health Care Flexible Spending Account	Minimum	Maximum
24 deduction period employees	$ 8.00	$132.00
16 deduction period employees (at regents)	$12.00	$198.00
Dependent Care Flexible Spending Account	Minimum	Maximum
24 deduction period employees	$16.00	$208.33*
16 deduction period employees (at regents)	$24.00	$312.50*

*Subject to tax filing status

Filing for Reimbursement

The employee files claims for reimbursement during the year to ASI (Application Software Inc.), the flexible spending account claims manager. Claim forms are sent by ASI to each member after the start of the new calendar year. Claim forms are also available in each agency human resources office and at ASI's website address: http://asiflex.com.

Health care and dependent care claims are reimbursed daily. Direct deposit of reimbursements to the employee's bank and e-mail notification of claims paid is available and encouraged for quicker deposit and availability of reimbursed funds.

ASI Telephone Number
800-366-4827 Automated Infoline (available 24 hours per day)

(Correspondents available 8 a.m. to 5 p.m. on workdays)

Mailing Address
ASI
PO Box 6044
Columbia, MO 65205-6044

Website Address
http://asiflex.com

Before enrolling in the KanElect Pretax Premium Option or KanElect Flexible Spending Accounts Program, employees should refer to the additional enrollment information in this booklet or in the Employee Benefits Guide at the following website:

State of Kansas Website Address
http://da.state.ks.us/ps/benefits.htm

Open Enrollment on the Internet

Beginning October 1, 2002, Kansas state employees can use the Internet to enroll for Plan Year 2003 Health Plans and Flexible Spending Accounts.

If an employee does not want to make <u>any</u> changes to Health Plan enrollment, they are not required to enter AKSESS to indicate "no change." **However, an employee must enter AKSESS to receive credit for the Health Risk Appraisal, to make Health Plan changes, or to participate or renew participation in a Flexible Spending Account for Plan Year 2003.** Please see the agency's Human Resources office for assistance.

<u>Things to know or do before enrolling on the Internet</u>:

<u>AKSESS passwords will not be mailed this year.</u> Instead, eligible members will be able to obtain their passwords directly from the AKSESS website: http://da.state.ks.us/aksess.

<u>To enroll</u>:

- Use a computer with Internet access when and where it is convenient – work, home, Job Service Centers, many public libraries.
- Go to the AKSESS website at http://da.state.ks.us/aksess. Follow the instructions on the screen to login (requires Employee ID and other member specific information)
- Create a password during initial login. Employees should create a password they will remember for future use.
- Update or initially enter a secret question and answer (prompted by the AKSESS system).
- Update or initially enter an email address (work, home or both).
- Select "Benefits Open Enrollment."
- Choose group health insurance coverage for the employee and dependents IF changing coverage. (This is a CHANGE ONLY open enrollment for health insurance.) Decide whether to select the Health Risk Appraisal credit. (**Must** select in order for this credit to be calculated into the rate.)
- Choose whether or not to enroll or change voluntary vision coverage. Members currently enrolled in the VSP option will be rolled over into the new Superior Vision Plan. If no coverage is desired, most elect to waive.
- Choose whether to enroll in Flexible Spending Accounts. (**MUST** re-enroll even if currently enrolled in order to apply to Plan Year 2003.)
- Submit/save changes. Print a confirmation of selections.
- Logout and close the browser. The browser settings will delete any temporary files stored on the computer so that others cannot view them.

<u>Forgot the password you created?</u>

Answer your secret question online and quickly receive a new password at your email address. If necessary, call the Help Desk to receive a new password.

<u>Need help on the website?</u>

AKSESS Help Desk is open from October 1-31, 8:00 AM to 5:00 PM, Monday through Friday, telephone (785) 368-8000. The help desk can only assist with signing in to the AKSESS system. Staff cannot answer questions about benefits options. For benefits options questions, contact the agency's Human Resources office, email aksess@state.ks.us, or go to http://da.state.ks.us/ps/benefits.htm

General Information

- The employee must elect how to pay for the cost of coverage - before tax or after-tax
- The employee must indicate if they are willing to participate in the Health Risk Appraisal to receive a $5 credit per semi-monthly deduction.

Medical Insurance Provider—Eligibility for all plans is determined by county of residence (based on the city and state of residence). AKSESS will display which plans are available in the employee's county of residence. For HMO's, the employee and all covered dependents must reside within the designated enrollment area for the State of Kansas group.

Note: Employees may waive medical, drug, and dental coverage and still enroll in the voluntary Vision Plan.

Medical and Prescription Drug Coverage Level—All employees and dependents with medical coverage will also have prescription drug coverage. Employees may choose from among the following coverage levels:

1 Member Only
2 Member and Spouse Only
3 Member and Child(ren) Only
4 Member and Family—with Spouse and Child(ren)

Dental Plan Administrator

- Delta Dental Plan of Kansas

Dental Coverage Level—Single dental coverage is provided for all employees enrolled in medical coverage. Employees may choose from the following coverage levels:

1 Member Only
D Member and Dependent(s)—dependent dental is available only if dependent medical coverage is selected; the dependents enrolled in the dental plan must match those enrolled in the medical plan. For example, if member and spouse coverage is chosen for medical, the employee can choose either member only coverage or member and spouse coverage for Dental.

Vision Coverage Level—Members currently enrolled in the voluntary vision plan administered by Vision Service Plan will automatically be transferred to the 2003 plan administered by Superior Vision Services unless they go on-line to change coverage. Otherwise, employees may elect any level of coverage on either the Basic or Enhanced Superior Vision Plan regardless of enrollment in a medical or dental insurance plan. Employees may choose from the following coverage levels:

1 Member Only
2 Member and Spouse Only
3 Member and Child(ren) Only
4 Member and Family—with Spouse and Child(ren)
5 Waive Vision Coverage

The dependent children enrolled in the vision plan must match those if enrolled in the medical plan.

Required Information—For each employee and covered dependent, the following information will be required:

- Relationship (e.g., child, spouse, stepchild, etc.) The State will request documentation to support proof of relationship or dependency.
- Full Name
- Social Security Number
- Gender
- Date of Birth
- PCP (Primary Care Physician) Number—for initial enrollment only on all HMO options. PCP designations should be made via AKSESS only if selecting a new HMO option. To change PCP without changing carriers, call the HMO.

Definition of a Dependent

A dependent is eligible for coverage under an employee's group health insurance coverage if they are one of the following:

A. An employee's lawful wife or husband. When the employee has been divorced from the lawful wife or husband, such spouse no longer qualifies as the employee's lawful wife or husband.

B. An employee's unmarried child who:
   1. is less than 23 years of age;
   2. does not file a joint tax return with another taxpayer;
   3. receives more than half of their support from the employee; and
   4. is a U.S. citizen, a U.S. national or a resident of the U.S., Canada or Mexico at some time during the tax year.

C. The child of an employee's covered dependent child if such grandchild resides in the employee's household and meets the criteria of subsection (B) (1) through (4).

D. An employee's unmarried child who is over the age of 23, and is not capable of self support because of mental retardation or severe physical handicap which existed prior to attaining age 23, and who has maintained continuous group coverage as a dependent child prior to attaining age 23. Such child must be chiefly dependent on the employee for support.

E. The word "child" means in addition to the employee's own or lawfully adopted child, any stepchild, or child for whom the employee has legal custody. If the employee has been divorced from the natural parent of the stepchild(ren), such child(ren) no longer qualify as the employee's stepchild(ren). As used in the preceding sentence, the term natural parent includes an adoptive parent.

Definition of dependent is further interpreted to mean the following:

- Children of divorced parents—An employee may cover their dependent children if they receive at least 50% of their support from one or both parents. The noncustodial parent who contributes $1,200 per year per child for support is presumed to have provided more than one half of the support of the child.

- Grandchild—An employee may cover a grandchild if the employee has legal custody or has adopted the child; or if the grandchild lives in the employee's home, is the child of a covered dependent child, and the employee provides more than one half of the grandchild's support. Special consideration may be given to a grandchild not living with the member, if the parent is a college student.

- A person who is eligible for coverage as an employee of the State is not eligible to be a covered dependent under the state Health Plan.

- Dependent children and/or stepchildren of State of Kansas employees are not eligible for duplicate coverage under the state Health Plan.

- Dependents residing out-of-country

  A spouse who is not a U.S. citizen or who resides in another country is eligible for PPO or indemnity plan coverage when the employee is newly eligible, when newly married or at Open Enrollment. The employee will not be allowed to add the spouse to coverage if the spouse moves to the United States during the plan year.

  Dependent children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move to the United States. The employee will be allowed to add the children to coverage if the children move to the United States during the plan year (if added within 31 days of the move). However, if added to PPO or indemnity plan coverage and the dependent children later return to another country during the plan year, coverage may not be dropped for these children until the next Open Enrollment period (unless enrollment is on an after-tax basis).

- Adopted child—An employee may cover an adopted child if the petition for adoption has been filed with the court, the employee has a placement agreement for adoption, or if the employee has been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to the Benefits Unit. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they reside in the United States.

To be enrolled as a dependent under an employee's coverage in the state Health Plan, the employee and the dependent must be enrolled with the same insurance provider.

Note: The State of Kansas reserves the right to request documentation to support proof of dependency and/or residency.

IMPORTANT TELEPHONE NUMBERS

MEDICAL PROVIDERS

Kansas Choice	Outside Topeka	800-332-0307
	In Topeka	785-291-4185
Coventry Health Care	Kansas City Area	800-969-3343
	Wichita Area	866-320-0697
Mid America Health	Outside Kansas City Area	800-632-4761
	Kansas City Area	816-460-4655
Kansas Prefer (Harrington Benefits)	All locations	800-882-3639
Preferred Health Systems	Outside Wichita	866-618-1691
	In Wichita	316-609-2555
Preferred Plus of Kansas	Outside Wichita	866-618-1691
	In Wichita	316-609-2555
Premier Blue	Outside Topeka	800-332-0028
	In Topeka	785-291-4010

DENTAL PROVIDER

Delta Dental Plan of Kansas	Outside Wichita	800-234-3375
	In Wichita	316-264-4511

PRESCRIPTION DRUG PROVIDER

AdvancePCS	All Areas	800-294-6324

VISION PROVIDER

Superior Vision Services	All Areas	800-507-3800

FLEXIBLE SPENDING ACCOUNTS

ASI	All Areas	800-366-4827

Note: The information in this booklet is intended to summarize the benefits offered in language that is clear and easy to understand. Every effort has been made to ensure that this information is accurate. It is not intended to replace the legal plan document or contract which contains the complete provisions of a program. In case of any discrepancy between this booklet and the legal plan document or contract, the legal plan document or contract will govern in all cases. An employee may review the legal plan document or contract upon request. The Health Care Commission reserves the right to suspend, revoke or modify the benefit programs offered to employees.

Nothing in this booklet shall be construed as a contract of employment between the State of Kansas and any employee, nor as a guarantee of any employee to be continued in the employment of the State, nor as a limitation on the right of the State to discharge any of its employees with or without cause.